BRECKENRIDGE DECL. EXHIBIT 3

	MTL 21/03
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1200
MEDICAID SERVICES MANUAL	Subject: INTRODUCITON

1200 INTRODUCTION

The Nevada Medicaid Pharmacy Services program pays for medically necessary prescription services for eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions hereinafter specified.

All providers participating in the Medicaid program must furnish services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Services.

This Chapter describes covered services, service limitations, and general reimbursement methodology.

This manual obsoletes all previous policy and procedure manuals, bulletins and policy news.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

	MTL 44/03
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1201
MEDICAID SERVICES MANUAL	Subject: AUTHORITY

1201 AUTHORITY

1. The Code of Federal Regulations, Title 42, Public Health, Chapter IV Center for Medicare and Medicaid Services, Subchapter C Medical Assistance Programs, Parts 430 through 456, states prescription drug coverage is an optional service under Title XIX.

2. The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandates additional preventive health care services for infants, children and young adults (newborn through age 20) eligible for Medicaid. These mandates provide that children and adolescents under age 21 receive follow-up services for a medically necessary condition discovered in a screening examination (EPDST) see Chapter; this includes prescription services.

3. CFR Title 42 and Section 1927 of the Social Security Act, require states to provide for a drug utilization review (DUR) program for covered outpatient drugs in order to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results (SSA, Title 19, (g)(1)(A)).

4. Section 1927 of the Social Security Act allows for a state to subject to prior authorization any covered outpatient drug, providing the prior authorization program complies with the requirements outlined in the act.

5. Chapter 422 of NRS amended by AB384 to require the Department of Human Resources to; 1) develop a list of preferred prescription drugs, 2) manage prescription drug use through the use of prior authorization and step therapy, and 3) create the Pharmacy and Therapeutics Committee.

	MTL 44/03
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1202
MEDICAID SERVICES MANUAL	Subject: DEFINITIONS

1202 DEFINITIONS

1202.1 ACTUAL ACQUISITION COST (AAC)

Actual Acquisition Cost (AAC) is the actual price paid by the pharmacy for a drug.

1202.2 COMPOUND DRUGS

Compound means to form or make up a composite product by combining two or more different ingredients.

1202.3 DEPARTMENT OF JUSTICE (DOJ) PRICING

In 2000, the US Department of Justice (DOJ) and the National Association of Medicaid Fraud Control Units (NAMFCU) determine that some drug manufacturers were reporting inaccurate average wholesale prices (AWPs) for some of their products. As a result, the DOJ and the NAMFCU compiled new pricing data gathered from several wholesale drug catalogs for approximately 400 national drug codes. The State Medicaid programs had the option to implement this revised pricing from the investigation. Nevada Medicaid chose to implement the pricing algorithm at the time of its inception. The pricing is reflective of the data file from First Date Bank.

1202.4 DISPENSING FEE

Dispensing fee is the dollar amount established for dispensing covered pharmaceuticals.

1202.5 DRUG USE REVIEW (DUR) BOARD

A drug use review program that consists of prospective drug use review, the application of explicit predetermined standards, and an educational program. The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and that they are not likely to result in adverse medical results. (CFR 456 I.B) The board consists of pharmacists and physicians.

1202.6 ESSENTIAL MEDICATIONS

Essential medications are those which are medically necessary to counteract severe pain and/or to sustain life, limb or eyesight. Restorative, rehabilitative, preventive, and maintenance medications must have appropriate corresponding diagnoses in the patient's chart to be considered medically necessary.

1202.7 ESTIMATED ACQUISITION COST (EAC)

Estimated Acquisition Cost (EAC) is defined by Nevada Medicaid as average wholesale price less fifteen percent (AWP - 15%). EAC is based upon the original package or container size from which the prescription is dispensed.

1202.8 EXPERIMENTAL

A drug prescribed for a use that is not a medically accepted indication. The term medically accepted indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citation included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

1202.9 FEDERAL UPPER LIMIT (FUL)

Under the authority of 45 CFR, Part 19, the Pharmaceutical Reimbursement Board of the U.S. Department of Health and Human Services has determined the maximum allowable ingredient costs. These limits apply to all Medicaid prescriptions unless exempted as "Medically necessary" by the prescriber (see 1203.1D(B)(3)) of this chapter. The upper limit for multiple source drugs meets the criteria set forth in 42 CFR 447-332 and 1927(e) of the Act, as amended by OBRA 1993. The development of the current Federal Upper Limit (FUL) listing has been accomplished by computer. Payments for identified multiple source drugs must not exceed, in the aggregate, payment levels determined by applying to each drug entity a reasonable dispensing fee (established by the state and specified in the State Plan), plus an amount based on the limit per unit which CMS has determined to be equal to 150 percent applied to the lowest price listed (in package sizes of 100 units, unless otherwise noted) in any of the published compendia of cost information of drugs. The listing can be obtained from the First Data Bank (Blue Book), Medi-Span, and the Red Book. The commonly known brand names are included in the FUL listing provided to the state agencies in electronic media format. The FUL price list will be updated approximately every six (6) months. This listing is now available on the CMS homepage at http://www.CMS.gov/medicaid/drughmpg/htm.

1202.10 GENERAL PUBLIC

General Public is defined as the patient group accounting for the largest number of non-Medicaid prescriptions from a pharmacy. This excludes patients who purchase or receive prescriptions through third party payers such as Blue Cross, Aetna, PAID, PCS, etc. If a pharmacy discounts prices to specified customers, e.g., 10% discount to senior citizens, these lower prices should be

excluded from usual and customary calculations unless they represent more than 50% of the store's prescription volume.

1202.11 INPATIENTS

Inpatients are those individuals receiving room, board, and medical care in a general or specialty hospital or nursing facility. Individuals living in Adult Group or Child Care Facilities are not considered inpatients. Persons who are bedfast and receiving home health care in a private residence are not considered inpatients.

1202.12 LEGEND DRUGS

Legend pharmaceuticals are those bearing the insignia "Rx only" on the label, and/or bearing statement "Caution: federal law prohibits dispensing without a prescription."

1202.13 MAINTENANCE DRUG

Maintenance Drug is defined as any drug used continuously for a chronic condition. Refer to Section 1203.1A(5)(c) of this Chapter.

1202.14 MAXIMUM ALLOWABLE COST (MAC)

Maximum Allowable Cost (MAC) is the lower of (1) the cost established by the Center for Medicaid and Medicare Services (CMS) for multiple source drugs that meet the criteria set forth in 42 CFR 447.332 and 1927 (f)(2) of the Act, or (2) the cost established by DHCFP for multiple source drugs under the State Maximum Allowable Cost.

1203.15 MULTIPLE SOURCE DRUGS

Multiple Source Drugs is defined in §1927 (k) (7) of the Social Security Act as, "covered outpatient drug for which there are two or more drug products which (I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutically Equivalence Evaluations"), (II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and (III) are sold or marketed in the State during the period."

1202.16 NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)

The National Council for Prescription Drug Programs, Inc. is a not-for-profit Standards Developmental Organization representing the pharmacy services industry.

1202.17 NON-LEGEND DRUGS

Non-legend pharmaceuticals are those not bearing the insignia "Rx only" on the label, and/or "Caution: federal law prohibits dispensing without a prescription." Non-legend pharmaceuticals may also be known as "over-the-counter" drugs.

1202.18 OBRA 90 DRUG REBATE

Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS's Center for Medicaid and State Operations (CMSO). The law was amended by the Veterans Health Care Act of 1992 which also requires a drug manufacturer to enter into discount pricing agreements with the Department of Veteran's Affairs and with covered entities funded by the Public Health Service in order to have its drugs covered by Medicaid.

1202.19 PHARMACEUTICALS

Pharmaceuticals are any drug, compound, mixture, or preparations which the U.S. Food and Drug Administration has approved for medical use.

Controlled pharmaceuticals are those pharmaceuticals listed in the schedule of substances, controlled by the Drug Enforcement Administration and/or the State Board of Pharmacy.

1202.20 PHARMACY AND THERAPEUTICS (P & T) COMMITTEE

P & T Committee is established under NRS. The P&T Committee is comprised of physicians and pharmacist to (I) identify the prescription drugs that are included or excluded on the preferred drug list for Title XIX and Title XXI programs, (II) identify the therapeutic classes for review and clinical analysis, and (III) review at least annually the therapeutic classes on the preferred drug list.

1202.21 POINT OF SALE (POS)

Point of Sale is a computerized claims adjudication system allowing pharmacies real-time access to recipient eligibility, drug coverage, pricing and payment information, and prospective drug utilization review across all network pharmacies.

1202.22 PREFERRED DRUG LIST (PDL)

The PDL is a listing of preferred outpatient drugs within specific therapeutic categories that have been identified, reviewed, and approved by the Pharmacy and Therapeutics Committee.

1202.23 PROSPECTIVE DRUG UTILIZATION REVIEW (PRO-DUR)

Prospective Drug Utilization Review encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening.

1202.24 SCHOOL OF MEDICINE

The facility referred to in this chapter shall mean the University of Nevada School of Medicine, Reno and Las Vegas.

1202.25 SINGLE SOURCE DRUG

Single Source Drug is defined in SS 1927(k)(7) of the Social Security Act as, "a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application."

1202.26 STEP THERAPY

The process of beginning drug therapy for a medical condition with the safest and most effective lower risk drug therapy and progressing to other drug regimens only if medically necessary. Step therapy protocols are developed at a therapeutic class level, and approved through the Drug Use Review Board based upon clinical practice guidelines, without consideration of the cost of prescription drugs. Step therapy guidelines may be implemented through a prior authorization process, prospective Drug Use Review edits, and/or provider educational programs.

1202.27 SUPPLEMENTAL REBATES

Supplemental rebates are drug rebates collected from the manufacturer above the rebates collected under the OBRA 90 Drug Rebate Program. Section 927(a)(1) of the Social Security Act provides that "the Secretary may authorize a State to enter directly into agreements with a manufacturer." Per CMS,SMDL#02-014, "States may enter separate or supplemental drug rebate agreements as long as such agreements achieve drug rebates equal to or greater than the drug rebates set forth in the Secretary's national rebate agreement with drug manufacturers, which is published at 56 F.R.7049 (1991).

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1202.28 UNIT DOSE

A unit dose drug is that quantity of a drug which is packaged as a single dose by the manufacturer.

1202.29 USUAL CHARGE

A pharmacy may not charge Medicaid more than the general public.

	MTL 41/05
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

1203 POLICY

Nevada Medicaid reimburses pharmacies for prescriptions dispensed to each Medicaid recipient, with a maximum of a 34-day supply. Maintenance medications have a maximum of 100 day supply.

1203.1 PHARMACEUTICALS

All legend and non-legend pharmaceuticals must be prescribed by a licensed physician, podiatrist, osteopath, dentist, advanced practitioner of nursing, or physician assistant within the scope of their practice.

1203.1A COVERAGE AND LIMITATIONS

1. Covered:

The Nevada Medicaid Drug program will pay for the following prescribed pharmaceuticals with a written prescription and may be subject to restrictions (such as Prior Authorization, Quantity Limitations etc):

a. Legend pharmaceuticals manufactured by companies participating in the federal Medicaid Drug Rebate Program, not on the excluded list (see below);
b. Preferred Drug List (PDL) is a list of covered outpatient drugs established upon recommendations from the P&T Committee. Reference Program Services Manual Chapter 200 for the P&T bylaws. Pharmaceuticals not on the preferred drug list, but within drug categories reviewed by the P & T Committee require prior authorization, unless exempt under NRS or federal law, excluded through recommendations of the P&T Committee or excluded by Division of Health Care Financing and Policy.
    1. New pharmaceutical products not within reviewed PDL categories and excluded under state plan are available under prior authorization guidelines until the P&T Committee can review the product or evidence.
    2. Existing pharmaceutical products for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs and are not excluded under state plan, are available under prior authorization guidelines until the P&T Committee can review the new evidence.
    3. Pharmaceuticals may require prior authorization due to step therapy protocols regardless of inclusion in the PDL.
    4. If the P&T Committee determines that there are no significant differences between drugs within a specific category based on clinical efficacy and safety, DHCFP or contractor may consider cost in determining which drugs are selected for inclusion on the PDL.

5. The Drug Use Review Board shall not be required to develop, review or approve prior authorization policies necessary for the operations of the PDL.

c. Pharmaceuticals prescribed for a medically accepted indication;

d. Family planning items such as diaphragms, condoms, foams and jellies.

Reference Appendix A for coverage and limitations of medications with special criteria.

2. Excluded:

The Nevada Medicaid Drug program will not reimburse for the following pharmaceuticals:

a. Agents used for weight loss.

b. Agents used to promote fertility.

c. Agents used for cosmetic purposes or hair growth.

d. Yohimbine.

e. DESI list "Less than Effective Drugs"
In accordance with current policy, federal financial participation is not allowed for any drug on the Federal Upper Limit (FUL) listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the Drug Efficacy Study and Implementation (DESI) program which has been found to be a less than effective or is identical, related or similar (IRS) to the DESI drug. The DESI drug is identified by the Food and Drug Administration or reported by the drug manufacturer for purposes of the Medicaid drug rebate program. This listing is available on the CMS website at http://www.CMS.gov/medicaid/drugs/desi. This includes pharmaceuticals designated "ineffective" or "less than effective" (including identical, related or similar drugs) by the Food and Drug Administration (FDA) as to substance or diagnosis for which prescribed.

f. Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed. See definition 1202.7 of this Chapter.
Pharmaceuticals manufactured by companies not participating in the federal Medicaid Drug Rebate Program unless rated "1-A" by the FDA.

g. Agents used for impotence/erectile dysfunction.

3. Refills:

A refill is a prescription subject to the limitations below:

a. Authorized refills are valid only from the pharmaceutical provider dispensing the original prescription, pursuant to Nevada Administrative Code (NAC) 639.712 and 639.714

b. Refill intervals must be consistent with the dosage schedule indicated on the original prescription. (ex. A prescription is written for 100 doses of a medication with directions of one tablet 3 times a day. This prescription is for a 34-day supply. A

consistent refill would be expected in 30 days; an inconsistent refill date would be 20 days from the original fill.)

c. Lost Medications. Nevada Medicaid does not pay for replacement of lost, stolen or otherwise destroyed medications even if a physician writes a new prescription for the medication. It is the responsibility of the recipient to replace these medications. Prior authorization may be granted in life-threatening situations and for maintenance medications (see Section 1203.1A(5)(c) of this Chapter) only.

4. Early Refills

Nevada Medicaid only pays for up to a 34 day supply of medications (100 day supply for maintenance medications) for recipients each month. A prescription refill will be paid for by Nevada Medicaid only when 80% of the prescription is used in accordance with the prescriber's orders on the prescription and on the label of the medication.

In the instance that a recipient will be out of town when a refill is due, the pharmacist may enter the appropriate override code to allow an early refill (refer to the POS Manual for a list of acceptable overrides). This override will be monitored by Nevada Medicaid for misuse/abuse by the recipient and/or provider.

Medicaid will not pay for an early prescription refill when gross negligence or failure to follow prescriber's prescription instructions has been displayed by the recipient.

5. Quantity of medication

The maximum quantity of medication per prescription payable by the Medicaid program is a 34 day supply. Exceptions are allowed for maintenance medications. (See Section 1203.1A(5)(c) of this Chapter.)

a. In long-term care facilities, if the prescriber fails to indicate the duration of therapy for a maintenance drug, the pharmacy must estimate and provide at least a 30-day supply. Exceptions may be based on reasonable stop orders. (For oral liquid medications only, a 16 fluid ounce quantity will be considered sufficient to fulfill the 30-day supply requirement.)

b. Prescription quantities may be reviewed; in those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the dispensing fee may be disallowed.

c. The maximum quantity of medication per prescription for maintenance pharmaceuticals for chronic conditions for outpatients, payable by Medicaid, may be a 100-day supply. The following drug categories are considered maintenance medications:

1. Antianginals
2. Antiarrhythmics
3. Anticonvulsants

4. Antidiabetics
5. Antihypertensives
6. Cardiac Glycosides
7. Diuretics
8. Thyroid preparations
9. Estrogens
10. Progesterone
11. Oral/Topical Contraceptives

6. Time Limits

Claims and adjustment requests must be submitted within the following time frames:

a. Claims not involving other third party payments must be received no later than 180 days after the date of service.
b. Claims involving other third party payors must be received no later than 1 year after the date of service. A copy of the Explanation of Benefits (EOB) from the other third party payer must be attached to the claim.
c. Claims returned by the Fiscal Agent for additional information or correction must be resubmitted to the Fiscal Agent within 180 days from the date on the return form.
d. Requests for adjustment to paid claims, including zero paid claims, must be received no later than 180 days after the date of payment (date of remittance advice).
e. Claims for persons who are retroactively determined eligible for Medicaid must be received no later than 180 days after the date of eligibility determination or the date of service, whichever is later.
f. Prior Authorization Request time requirements. In accordance with 42 CFR Section (d)(5)(A), all service request determinations will be issued by the Nevada Medicaid Quality Improvement Organization (QIO-like vendor) by telephone or other telecommunication device (fax) within 24 hours of the receipt of such request.

7. Emergency supply of medication

a. In an emergency situation, after QIO-like vendor working hours and weekends, dispensing of a 72-hour supply of those covered outpatient drugs that require prior authorization will be allowed.
b. Nevada Medicaid requires prior payment authorization for medications identified as requiring prior authorization (PA).
c. The physician must indicate the diagnosis on the prescription (preferably with an ICD-9 code) to support the use of the emergency policy.
d. As a follow-up to the dispensing of the emergency supply of medication, the provider must contact the QIO-like vendor, to obtain a verbal verification number.

8. Nevada Check Up

All coverage and limitation policies and rules, including any PA requirements, outlined in this chapter apply to Nevada Checkup recipients as well as Nevada Medicaid Fee for Service recipients. There are NO exceptions.

9. Immunizations

Unless otherwise stated in this chapter, immunizations are covered without prior authorization. Reference Appendix A.

1203.1B PROVIDER RESPONSIBILITY

1. Any pharmacy, pharmacist or prescribing practitioner who has a current license or registration, and who is licensed by his respective state, and who is free from any Pharmacy Board restriction by any state, may apply to become a participating provider under this program.
   a. Each in-state pharmaceutical provider must have entered into a written contract, signed by the provider and/or his representative, with Nevada Medicaid to acquire participating status and must comply with federal, state and Medicaid regulations and procedures.
   b. The pharmaceutical provider will maintain records for all prescriptions dispensed to eligible recipients as may be required.
      1. The provider will allow, upon request of proper representative, access to all records that pertain to Medicaid recipients for fiscal review, audit or utilization review.
      2. All fiscal records are to be maintained for a period of six years or as specified in federal regulation.
   c. Application for participation may be made by phone or letter to the Nevada Medicaid Office at the location noted in the reference Section 1205.2.C. of this Chapter. Nevada Medicaid reserves the right to reject any request for participation.
   d. A current list of providers may be obtained through Medicaid's Fiscal Agent.

2. UTILIZATION CONTROL

   a. <u>Prospective (Concurrent) Drug Utilization Review (Pro-DUR)</u>
   Pro-DUR functions will be carried out via the Point of Sale (POS) Systems, see Section 1203.1(D)3 of this Chapter. However, verification of eligibility by provider review of the recipient's current Medicaid card at the time of service remains a necessary responsibility of the provider.
      1. Pro-DUR edits apply to POS claims and paper (UCF) claims.
      2. LTC claims are subject to all Pro-DUR edits that apply to retail.

3. Providers may submit override codes using the NCPDP standard interactive DUR codes. Override codes may be submitted on the initial claim. A denied claim does not have to be on file.
4. No long term PA's are issued, codes must be entered each time error occurs.

Reference the provider manual provided by the Nevada Medicaid POS system contractor for more information on the current Pro-DUR edits and override procedures.

b. Retro Drug Utilization Review

Both recipient and provider profiles (i.e. claim payments) are reviewed to identify patterns of excess. Verification of receipt of services is ongoing on a sample basis. Providers may be audited on site.

c. Drug Utilization Review (DUR)

Nevada Medicaid policy and federal law allows the state appointed DUR committee to conduct review of the information compiled about individual clients and providers and allows the DUR committee to educate Medicaid providers about the changes in ambulatory therapeutics. Educational programs may include information such as drug interactions between medications physicians have prescribed for the patients, and medications they are prescribing that are unnecessarily expensive. In this case, educational efforts will be directed to help providers improve their efficiency in the allocation of the finite resources available for Medicaid clients.

d. Eligibility

Eligibility for Medicaid services is verified by possession of a Medicaid card valid for the current month.

1. Medicaid cards printed "A" or "M" mean Qualified Medicare Beneficiary (QMB); "A" is eligible for full Medicaid Services; "M" is eligible only for Medicare deductible and co-insurance, no other Medicaid services. A recipient card marked with a "P" is eligible only for pregnancy-related services, no others.
2. When patients claim Medicaid eligibility but do not have a computer generated Medicaid card, eligibility may be verified through the EVE system or by contacting the appropriate Nevada State Welfare District Office (see Section 1205).
3. Managed Care – HMO: All reimbursement is subject to the enrolled health plan limitations. Contact instructions are noted on each recipient's Medicaid card.
4. Lock-in Program: When a recipient has shown patterns of abuse/misuse of Nevada Medicaid benefits, the recipient may be "locked-in" to a pharmacy or provider. This means the recipient can only obtain payment for prescriptions/medical service at a single pharmacy/provider of the recipient's choice. An edit will be placed in the POS system that will not allow another pharmacy/provider to bill for the service, and a Pro-DUR message will be given at the time of service to notify the provider that the recipient is "locked-in" at another facility.

3. GENERIC SUBSTITUTION

Per NRS 639.2583, if the practitioner has not indicated that generic substitution is prohibited, the pharmacy provider must dispense, in substitution, "another drug which is available to him if the other drug:

a. is less expensive than the drug prescribed by brand name;
b. is biologically equivalent to the drug prescribed by brand name;
c. has the same active ingredient or ingredient of the same strength, quantity and form of dosage as the drug prescribed by brand name; and
d. is of the same generic type as the drug prescribed by brand name the least expensive of the drugs that are available to him for substitution".

The pharmacy provider shall substitute the least expensive of the drugs available to him/her for substitution.

4. PRESCRIBER BRAND CERTIFICATION

Upper Limit cost limitations specified in this Chapter will not apply when a prescriber certifies that a specific brand of medication is medically necessary for a particular patient. The physician should document in the patient's medical record the need for the brand name product in place of the generic form. The procedure for certification must comply with the following:

a. The certification must be in the physician's own handwriting.
b. Certification must be written directly on the prescription blank.
c. The phrase "Dispense as written" is required on the face of the prescription. For electronically transmitted prescriptions "Dispense as written" must be noted.

   Not acceptable: A printed box on the prescription blank checked by the prescriber to indicate "brand necessary" or a handwritten statement transferred to a rubber stamp and then stamped on the prescription.

d. A prior authorization is not required unless subject to Section 1203.1(A)1-2 or Appendix A of this Chapter.
e. Certification is not required if a generic is not manufactured.
f. A fax copy/verbal order may be taken by the pharmacist from the physician but the pharmacy must obtain an original printed copy and keep on file.

1203.1C RECIPIENT RESPONSIBILITY

1. Recipient must report any changes that might affect Medicaid eligibility, such as changes in family income or a move to another country or state. They must also notify the Welfare District Office if they buy health insurance or become covered under another person's health insurance.

2. Recipient are encouraged to receive prescriptions in one pharmacy of their choice for continuity of care. They must inform providers that they are a Medicaid recipient and show a Medicaid card prior to services. Recipients are also responsible for informing providers of any other insurance that may cover medical services.

3. If approved for Medicaid retroactively, recipients must notify providers of Medicaid eligibility on receipt of a Medicaid card.

4. Recipients are responsible for charges incurred during any time of ineligibility for Medicaid.

1203.1D REIMBURSEMENT

Medicaid will pay for those pharmaceuticals dispensed to eligible recipients in accordance with the procedures and limitations outlined in this chapter. Medicaid also purchases certain durable/disposable medical supplies and nutritional supplements outlined in Chapter 1300 of the Medicaid Services Manual.

1. PRIOR RESOURCES

The Medicaid program assumes liability for payment only after group and/or private insurance, or other third party benefits are exhausted. Benefits available free of charge to recipients from other sources are considered a prior resource.

2. LEGEND DRUGS

Reimbursement for legend drugs, not including multiple source drugs with specific upper payment established, must not exceed, in the aggregate, reimbursement of the lower of 1) Estimated Acquisition Cost defined as Average Wholesale Price minus fifteen (15) percent plus a dispensing fee of $4.76 per prescription, or 2) Provider's usual and customary charges to the general public, or 3) Department of Justice pricing minus 15% plus a dispensing fee of $4.76 per prescription. (Reference Section 1202.14 of this Chapter, for of legend drug)

3. NON LEGEND DRUGS

Reimbursement for non-legend drugs will be the lower of 1) Estimated Acquisition Cost defined as Average Wholesale Price (AWP) minus fifteen (15) percent plus a dispensing fee of $4.76 per prescription, or 2) Provider's usual and customary charges to the general public. (Reference Section 1202.14 of this Chapter, for definition of legend drug)

4. COMPOUNDED DRUGS

Reimbursement for all compounded pharmaceuticals, providing at least one covered drug is included in therapeutic quantity, are paid using the NCPDP Multi-Ingredient Compound claim functionality. Drug coverage edits will be performed at the individual ingredient level. In addition, prior authorization requirements will be performed at the individual ingredient level. Reimbursement for topical compound claims and non-antibiotic IV therapy claims will be based on the reimbursement policy stated in 1203.1D.2. Reimbursement for IV antibiotic therapy claims will be reimbursed based on the policy contained in 1206. For detailed billing instructions, please refer to the Pharmacy Billing Manual at http://nevada.fhsc.com

5. DISPOSABLE MEDICAL SUPPLIES

Please refer to Chapter 1300 (DME) for instructions on billing and any applicable limitations for these items.

6. UNIT DOSE (REPACKAGE AND RE-STOCK)

REPACKAGE: Nevada Medicaid provides reimbursement incentives for Long Term Care (LTC) providers who repackage non-unit dose pharmaceuticals. An additional $0.43 per claim is given on pharmaceuticals that are repackaged for unit dose dispensing. Pharmaceuticals that First Data Bank classifies as unit does products are not covered for this policy.

RETURN OF UNUSED DRUGS PACKAGED IN UNIT DOSES: A ten percent (10%) restocking fee (ingredient cost only) will be given for the manufacturers' non-schedule II unit dose drugs. This restocking fee will be allowed for the following product types only: solid dosage forms (tablets and capsules), non-refrigerated nebulized medications, non-refrigerated injectables, and transdermal patches.

These incentives are available only to pharmacies supplying long-term care inpatients. The pharmacy provider must apply to the Nevada Medicaid Office, Program Services Unit to enroll in this incentive program.

7. THIRD PARTY LIABILITY

Medicaid is always payer of last resort whenever any other resource is responsible for payment. "Third Party" means any individual entity on program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a state Medicaid plan. Other medical resources include, but are not limited to, Medicare, private insurance, self-insured plans, and workers compensation insurance. The exceptions to this rule are Indian Health Services, and Children with Special Health Care Needs (previously

known as Crippled Children's Services), and state victims of crime. Medicaid is a prior resource to these programs.

Billing all other third party resources is mandated by federal and state law, and is one of the provisions of the Provider Agreement signed by participating Medicaid providers. In addition, a Medicaid provider cannot refuse to furnish Medicaid covered services to a Medicaid eligible individual due to potential third party liability (TPL) for the services. However, if the provider does not participate in the recipient's other health care (OHC) plan, the provider should refer the recipient to the OHC plan. Nevada Medicaid may deny payment for the OHC plan covered services if the recipient elects to seek treatment from a provider not authorized by the OHC plan. If the Medicaid recipient voluntarily elects to receive Medicaid covered services from a provider who does not participate in the recipient's OHC plan, the recipient assumes the responsibility to pay for the services the same as a private pay only patient.

a. Coordination of Benefits (COB)

On-line COB (cost avoidance) is part of the Nevada Medicaid POS system.

1. If Nevada Medicaid is the recipient's secondary carrier, claims for COB will be accepted.
2. Nevada Medicaid is always the payer of last resort.
3. Other coverage will be identified by the presence of other carrier information on the recipient eligibility file.
4. If the recipient shows other coverage, the claim will be denied. The POS system will return a unique client-identified carrier code identifying the other carrier, the recipient's policy number and the carrier name in the additional message filed. It is possible that a recipient may have more than one active other carrier; in that case, the returned code will be from the first carrier, subsequent codes will be returned until fully exhausted. Providers will be required to submit this code OTHER PAYER ID (#340-7C) field as part of the override process.
5. Even if "no other insurance" is indicated on the eligibility file, the claim will be processed as a TPL claim if the pharmacy submits.
6. If other insurance is indicated on the eligibility file, the claim will be processed as a TPL regardless of what TPL codes the pharmacy submits.
7. In all cases, the Nevada Medicaid "allowed amount" will be used when calculating payment. In some cases, this may result in a "0" payment, when the insurance carrier pays more than the Medicaid "allowable amount".
8. In order to facilitate the TPL/COB process, Nevada Medicaid will allow providers to override "days supply limits" and/or "Drug Requires PA" conditions by entering a value of "5" (exemption from prescription limits) in the PA/MC CODE field (NCPCP #416DG) if there are no PA requirements on these drugs from the primary insurer.

b. Non-participating HMO Providers

1. Recipients who have Medicaid and HMO coverage, including Medicare HMOs, must seek treatment and services through their preferred provider network or HMO. Nevada Medicaid is not liable to pay for HMO covered services if the recipient elects to seek treatment from a provider not authorized by the HMO. Unless the provider is an authorized provider of a recipient's health plan, the recipient should be referred to the plan for covered treatment, or the provider should contact the HMO for treatment authorization.
2. Exceptions to Medicaid liability policy are:
   a. The service(s) is/are a non-covered benefit of the HMO plan;
   b. The service is an emergency and a participating provider is more than 25 miles away;
   c. The service is for family planning;
   d. The recipient resides outside the service area of the HMO; or
   e. The recipient's HMO coverage has been exhausted.

8. PHARMACY BILLING PROCESS

a. National Council for Prescription Drug Program (NCPDP) Standard Billing Units

Nevada Medicaid reimburses for outpatient pharmaceuticals according to NCPDP "Billing Unit Standard Format" guidelines. The standard provides for the billing of pharmaceuticals in one of three billing units for all drug products. These units are "each", "milliliter (ml)", and "gram (g)". The following guidelines are to be used when billing Nevada Medicaid for pharmaceuticals:

Tablets, Capsules, Suppositories, Prefilled Syringes: must be billed by "each". For example, if 30 tablets of Metformin are dispensed, the quantity will be 30.

Liquids, Liquid Orals, Suspensions, Solutions, Opthalmic/Otic Solutions: must be billed by milliliters (mls). For example, if 560ml of guiafenesin is dispensed, the quantity entered will be 560. PLEASE NOTE:

Ounces must be converted to ml (1 ounce = 30ml).
Liters must be converted to ml (1L = 1000ml).
Ointments, Bulk Powders: must be billed by grams. For example, if a two ounce tube of oxiconazole nitrate is dispensed, the quantity entered will be 60.
PLEASE NOTE:

Ounces must be converted to grams (1 ounce = 30g, ½ ounce = 15g).

Oral Contraceptives/Therapy packs: must be billed per "each" tablet dispensed, not the number of packages. For example, Ortho Tri-cyclen is a 28-day dial pack, the quantity entered will be 28.

Transdermal Patches/Powder Packets: must be billed per "each" patch/packet dispensed, regardless of whether they are pre-packaged in a box or come in individual pouches/packets. For example, Catapress-TTS comes in a box of four patches. If two of these boxes are dispensed, the quantity entered will be 8.

Inhalers and Aerosols: must be billed as either grams or ml, as specified by the manufacturer on the labeling. For example a 90mcg(microgram)/inh Albuterol Inhaler has a total of 17gm in the canister. If one of these is dispensed, 17 will be quantity entered.

Topical Products: must be billed as either grams or ml, as specified by the manufacturer on the labeling.
PLEASE NOTE: Ounces must be converted to grams or ml.

1 ounce = 30ml
1 ounce = 30g

Reconstitutables (oral, otic, ophthalmic): must be billed per ml that are/will be in the bottle after reconstitution according to the manufacturer's instructions.

Liquid Injectables (vials, ampoules): must be billed by milliliters (ml). For example, if a 10ml vial of Novolin 70/30 is dispensed, the quantity entered will be 10.

Powdered Injectables (vials): must be billed by "each" vial given per dose. For example if the recipient receives Ampicillin 1g every 6 hours for 1 week, the quantity entered will be 1, as only one vial is used per dose (assuming a 1gm vial is used), and the # of doses entered will be 28 (4 per day x 7 days). PLEASE NOTE: If the product is supplied with a diluent, the quantity entered is only the number of powdered vials dispensed, the diluent is not factored in.
Intravenous Solutions: must be billed in ml administered per dose. For example, if a recipient receives 250ml of Normal Saline four times per day, the quantity entered will be 250, as that is the quantity per dose.

Blood Derived Products: products may vary in potency from batch to batch. Anithemophilic products must be billed as the number of antihemophilic units dispensed (each). Prolastin must similarly be billed as the number of milligrams dispensed (each).

Kits: defined as products with a least two (2) different or discreet items (excluding diluents, applicators and activation devices) in the same package, intended for dispensing as a unit. Kits carry only a single NDC. Kits are intended to be dispensed as a unit and should be billed as a unit of each kit dispensed (each).

For further information, refer to the NCPDP Billing Unit Standard Format Official Release.

b. Provider/Dummy Numbers

The state NABP provider number is to be used and entered when billing online using the POS system or when using the UCF.

For prescriptions written by out of state providers, non-Medicaid provider, or written by residents in residency programs, state assigned "dummy numbers" will be provided. Each neighboring state and each residency program will be assigned a unique "dummy" number. Nevada providers who are non-Medicaid providers will also have a unique "dummy" number. These numbers are only to be used when the prescriber does not have a Nevada Medicaid provider number. If over-utilization of these "dummy" numbers is noted, an audit may be performed on the pharmacy for the appropriateness of their use.

9. STATE MAXIMUM ALLOWABLE COST (MAC)

a. State Maximum Allowable Cost (MAC) is the upper reimbursement limit for multi-source outpatient pharmaceuticals established by the Department of Health Care Financing and Policy (DHCFP), or Fiscal Agent.
   1. DHCFP Fiscal Agent will perform ongoing market analysis to monitor pricing patterns and product availability.
   2. DHCFP Fiscal Agent will perform monthly updates of the drugs subject to the MAC.
   3. All drugs subject to the MAC and updates will be posted on the following website: http://nevada.fhsc.com

b. Providers may appeal the current state MAC for a pharmaceutical product if a provider determines that a particular multi-source drug is not available at the current state MAC reimbursement.
   1. The pharmacy must contact the Fiscal Agent technical call center to initiate the appeal.
   2. Information needed to make a decision will include NDC number, manufacturer, drug name, strength, and price paid. A faxed copy of the actual invoice for the drug may be requested.
   3. Inquiries not resolved by the technical call center are forwarded to the Fiscal Agent's MAC Coordinator for investigation and resolution.

4. If it is determined the MAC is negatively impacting access to care for recipients, the MAC Coordinator has the authority to 1) adjust MAC pricing for the particular claim being appealed, and 2) make changes to the MAC pricing file.
5. Appeals will be responded to within three working days of the referral to the MAC Coordinator.

1203.1E AUTHORIZATION PROCEDURES

PRIOR AUTHORIZATION (PA) REQUESTS: Physicians may request payment for exceptions to program limitations outlined in Section 1203.1A(1) of this Chapter and medications requiring prior authorization in Appendix A of this Chapter by forwarding a PA request to the Quality Improvement Organization (QIO-like vendor). The phone/fax number is located in Section 1205 of this Chapter.

1. When completing the PA providers must:

   a. Provide all relevant diagnoses.
   b. List all routine essential drugs being prescribed.
   c. The requesting physician must sign the PA and forward all copies to the QIO-like vendor. He/she will be advised by return copy of the decision. (A facsimile signature stamp is acceptable.)
   d. Unless otherwise indicated, by the QIO-like vendor, the PA is for no more than one 34-day supply of prescription for each authorized drug per month.

2. Prior Authorization Protocols:
   a. Alternate media (e.g. paper/UCF claims) are subject to all prior authorization types.
   b. LTC claims, regardless of the media type, are subject to all prior authorization types.
   c. Note that the POS system does not require a "PA Number" to be entered on a paper or electronic claim; the only requirement is that the PA record is activated in the system prior to the claim submission. The approved PA will be in the POS system and will be active for all pharmacies using the POS system, unless the recipient is "locked-in" to a particular pharmacy for abuse/misuse reasons.
   d. A prior authorization will typically be required to be requested and entered prior to the dispensing of the medication, however there may be situations in which an authorization request is considered after the fact (e.g. retroactive eligibility).
   e. For clinical prior authorizations in which a Clinical Call Centre PA Unit pharmacist or pharmacy technician requests information from the prescribing physician, the PA will deny if the doctor does not respond to a request for information within three working days.
   f. The Nevada Medicaid QIO-like vendor will send all denial of service letters.

g. For any prior authorization requests that are denied due to criteria not being met, the recipient (only) may appeal the decision. Reference Nevada Medicaid Chapter 3100 for the hearings process.

h. Standard protocols for "Emergency" or "72 Hour Fill" type of overrides will be used.

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1204
MEDICAID SERVICES MANUAL	Subject: HEARINGS

1204 HEARINGS

1204.1 Please reference Nevada Medicaid Services Manual, Chapter 3100 for the Medicaid Hearings process.

1205 REFERENCES AND CROSS REFERENCES

1205.1 PROVIDER SPECIFIC INFORMATION

Specific information about each provider type can be found in the following chapters:

Chapter 100	Eligibility, Coverage and Limitations
Chapter 1300	DME, Prostheses and Disposable Supplies
Chapter 3100	Medicaid Hearings
Chapter 3300	Surveillance and Utilization Review Section (SURS)
Chapter 3600	Managed Care Organization
Chapter 3700	Nevada Check Up

1205.2 CONTACTS

1. STATE OFFICES

a. Central Office

Nevada Division of Health Care Financing and Policy
Nevada Medicaid Office
1100 E. Williams Street
Carson City, Nevada 89701
Telephone: (775) 684-3600

b. District Offices

Nevada Division of Health Care Financing and Policy, Medicaid District Offices (DOS) are listed in various Medicaid pamphlets. Local telephone numbers are:

Carson City	(775) 684-0800
Elko	(775) 753-1191
Fallon	(775) 423-3161
Las Vegas - Belrose	(702) 486-1550
Reno - Bible Way	(775) 448-5000

1205.3 FIRST HEALTH SERVICES CORPORATION

PROVIDER RELATIONS UNITS
Provider Relations Department
First Health Services Corporation
PO Box 30026

Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

PRIOR AUTHORIZATION DEPARTMENTS
First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

PHARMACY POINT-OF-SALE DEPARTMENT
First Health Services Corporation
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238

1206 INTRAVENOUS (IV) THERAPY
PROVIDER TYPE 37

The purpose of I.V. Therapy is to sustain life, reduce or eliminate infections, replace or provide necessary chemicals to maintain electrolyte balance or provide blood product or chemotherapeutics. I.V. Therapy and treatment should only be used when the Medicaid recipient cannot use oral medications.

1. Billing Guidelines:

IV therapy is billed through the Pharmacy POS system using the multi-ingredient functionality. A 37 provider number is required (Home Infusion Therapy Provider) The paper Multi-ingredient UCF may also be used if an exception is granted by the Division. Drug coverage edits and prior-authorization edits will be performed at the individual ingredient level.

The billing units used should be the NCPDP standards of "each", milliliters (ml) or grams (g). Please refer to section 1203.1(D)(8) of this Chapter for complete explanation of these standards.

For specific instructions related to billing via the POS system, refer to the Claims Processing Manual provider by the Nevada Medicaid QIO or contact them by phone (see section 1205 Page 1 of this Chapter).

2. Dispensing Fees:

A daily dispensing fee of $22.40 will be applied to IV Therapy claims for outpatient antibiotic therapy. For recipients in Long Term Care, a daily dispensing fee of $16.80 will be applied to the claim. This will be multiplied by the number of days the therapy was provided.

3. Supplies:

Supplies for IV Therapy, Enteral Nutrition and TPN (Total Parenteral Nutrition) are billed through the DME program (under Provider Type 33). Please refer to Chapter 1300 (DME) for instructions on billing and any applicable limitations on these items.

4. Long Term Care:

a. Non-Billable Items
IV Hydration Therapy of standard fluids without additives (e.g., antibiotics, potassium, and heparin) as well as supplies associated with IV Therapy, Enteral Nutrition, and TPN administration are included in Nevada Medicaid's Long Term Care / Nursing Facilities rate and may not be billed as a separate charge.

b. Billable Items

IV Drugs/TPN for recipients in Long Term Care facilities may be billed as a separate charge. Please refer to Chapter 500 (Nursing Facilities) of the Medicaid Service Manuals for further information on items which may be billed separately to Nevada Medicaid.

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1207 INPATIENT/OTHER OUTPATIENT PHARMACY COVERAGE

1. Inpatient

All pharmacy services are included in the all inclusive daily per diem rate for inpatient services. Pharmacy charges may not be billed separately to Medicaid when a recipient is in an inpatient facility.

2. Other Outpatient (providers other than type 28 administering pharmaceuticals)

a. Emergency Room:
All pharmacy services are included in the Emergency Room charges. "Take Home" medications are also included in the facility rate and may not be billed separately.

b. Ambulatory/Outpatient Surgery/Hospital Based Ambulatory Infusion Center:
All pharmacy services are included in the facility rate for these outpatient clinics. Pharmacy charges may not be billed separately.

c. Physician Office/Clinic:
Pharmacy charges are billed separately, using the appropriate CPT code for administration of the drug. The drug is to be billed utilizing the appropriate HCPCs Codes at Redbook AWP (Average Wholesale Price). The provider is to enter the Redbook AWP under billed charges on the CMS 1500 and will be reimbursed at billed charges (Redbook AWP) minus fifteen percent (15%). Reference Chapter 1300 for billing of associated supplies.

d. Free Standing Infusion Clinic:
Reference Section 1206 of this chapter for Intravenous Therapy policy and procedures.

e. EPSDT (Early Periodic Screening, Diagnosis and Treatment)
All medications administered through the EPSDT program are to be billed using the appropriate CPT code on a CMS 1500. Childhood immunizations are reimbursed under the appropriate CPT code. Reimbursement is according to the Nevada Medicaid fee schedule.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL

CHAPTER 1200-PRESCRIBED DRUGS
APPENDIX A-TABLE OF CONTENTS

APPENDIX A – Coverage and Limitations

I. DRUGS REQUIRING A PRIOR AUTHORIZATION

A. Proton Pump Inhibitors (PPI'S)

PPI's are a covered Nevada Medicaid benefit for adult recipients with a diagnosis of Gastroesophageal Reflux Disease (GERD), or Peptic/Gastric Ulcer Disease (PUD), or Helicobacter Pylori or Hypersecretory Conditions (e.g. Barrett's Esophagus, Zollinger-Ellison) who meet the criteria for coverage.

1. Coverage and Limitations:

Approval will be given if the following are met and documented:

a. Gastric Esophageal Reflux Disease (GERD):

1. Lifestyle modification has been attempted/the prescriber documents attempts to educate recipient on lifestyle modification. This should include, but is not limited to, dietary changes, avoiding tight clothing, smoking cessation, reduction of meal size, elevation of HOB, etc. Consider NSAID/ASA use and discontinue use or switch recipient to Cox 2 if appropriate; and,
2. Over the Counter (OTC) antacid/acid suppression trial has been attempted. This must include trial of at least one OTC antacid and one OTC H2A in therapeutic dosage. Drug, dose, frequency and duration attempted must be documented on the Payment Authorization (PA) form. This trial, in conjunction with lifestyle modification, must be at least an four-week trial.

Approval of PPI will be for one year. A trial of H2A after each year for two weeks.

b. Peptic/Gastric Ulcer Disease (PUD):

1. Diagnosis of active gastric or duodenal ulcer must be confirmed with endoscopy or upper gastrointestinal (GI) series within the last 2 months. Documentation of attempt at/attempt to educate recipient regarding lifestyle modification must be present (see GERD for guidelines).
2. Helicobacter pylori test has been administered. If results are positive, see H. pylori guidelines below.

Approval of PPI will be for a 90-day time limit.

c. Hypersecretory Conditions (Barrett's Esophagus, Zollinger-Ellison etc)

Diagnosis must be confirmed with testing. Approval will be for a 12-month time period.

d. Helicobacter pylori (H. pylori)

1. Must be confirmed with testing (e.g. serologic, HpSA) and,
2. Combination therapy must be documented. Triple therapy (e.g. a bismuth salt, metronidazole and tetracycline or amoxicillin) or other regimen that combines one or more anti-infective agents with a bismuth salt and/or an antisecretory agent should also be considered.

Approval of PPI will be for a one-month limit.

e. GI Bleed

1. Diagnosis of active GI bleed within the past month.

Approval will be for a one-month limit.

If a PPI is prescribed concurrently with an H2A by the same prescriber, it will be considered duplicate therapy and will not be approved.

2. Covered Products:
All pharmaceutical PPI agents where the manufacturer of the product participates in the CMS rebate program and is compliant with all other Nevada Medicaid regulations (e.g. DESI drug status, etc.).

3. PA Guidelines:
The PA must be initiated by the prescriber, except in long-term care facilities where the attending nurse may initiate and certify the PA after a review of the recipient's chart has been completed.
PA form: Nevada Medicaid Prior Authorization Request for Proton Pump Inhibitors Form.

APPENDIX A – Coverage and Limitations

Nevada Medicaid
Prior Authorization Request for
Proton Pump Inhibitors

TO BE COMPLETED BY PRESCRIBER

Prescriber Medicaid Provider Number
_____

Prescriber's Name:_____
First Last

Phone (____)_____

FAX (____)_____
Phone & Fax must be completed

Recipient Medicaid ID Number
_____

Recipient's Name:_____
First Last

Date of Birth __/__/____

Sex: ☐ Female ☐ Male

Request Date: __/__/____

Drug Name:_____Strength:_____Dosage:_____Length of Therapy:_____

Diagnosis & ICD9:_____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Nevada Medicaid Agency.

*Prescriber's Signature*_____ *Date*_____

Coverage Criteria

At least one of the diagnoses below must be the treating diagnosis. All criteria for the diagnosis must be met as a condition for payment for this drug by Nevada Medicaid. Please limit the request to one drug per request form. Supporting documentation does not need to be attached to this form but must be available in the recipient's medical record.

Diagnosis of GERD

☐ Lifestyle modification attempted
☐ OTC antacid/acid suppression H2A trial has been attempted.

OTC Drug	Dosage	Duration

H2A Drug	Dosage	Duration

Approval will be for a 90 day time period

Diagnosis of GI Bleed

☐ Diagnosis of active GI Bleed confirmed by testing.

Approval will be for a 1 month limit.

Diagnosis of:

☐ **Hypersecretory Condition(Zollinger-Ellison)**
☐ **Barretts Esophagus**

Date of Test:__/__/____Result:

Diagnosis of Peptic Ulcer Disease (PUD)

☐ DX of active gastric or duodenal ulcer confirmed with endoscopy or upper GI series.
☐ Documentation of attempt to educate or attempt at lifestyle modification
☐ H.Pylori test has been administered

Date of Test:_____Result:_____

Diagnosis of Helicobacter Pylori

☐ Diagnosis confirmed by testing.
Test Performed: Date of Test: __/__/____

☐ Combination Therapy Documented:

Drug	Dosage	Duration

Approval will be for a 1 month limit.

FIRST HEALTH SERVICES USE ONLY:

Comments:_____

Date_____☐Approved ☐Changed ☐Denied ☐Pending Add'l Info

MAP RPh/Tech:_____

Submit Requests to:

First Health Services
MAP Department
4300 Cox Road
Glenn Allen, VA 23060

Fax: 1-800-229-3928
Tel: 1-800-505-9185

NMO/FH 3701 (01/03)

B. Cox 2 Inhibitors

Cox 2 Inhibitors are a covered benefit of Nevada Medicaid for adult recipients who meet the criteria for coverage.

1. Coverage and Limitations:
FDA Approved Indications:
   a. A diagnosis of osteoarthritis, degenerative joint disease, rheumatoid arthritis, dysmenorrheal, familial adenomatous polyposis (FAP) or acute pain in adults.
   b. Upon diagnosis of an FDA approved indication, authorization will be given if the patient meets all of the following criteria:
      1. Patient has no history of allergies to sulfonamides, aspirin or other NSAID's (non-steroidal anti-inflammatory drugs).
      2. Patient has a documented history of gastro-intestinal bleeding, ulceration or perforation of the stomach, small intestine or large intestine OR is being treated with oral corticosteroids or anticoagulants.
      3. Patient has a documented treatment history and/or failure of at least two non-selective (traditional) NSAIDs.
      4. Patient is currently NOT being treated daily with aspirin for cardio-prophylaxis.
      5. Patient does NOT have a documented history of cardiac events (i.e. stroke, myocardial infarction, or has NOT undergone of coronary artery bypass graft procedure in the past 6 months) or major cardiac risk factors such as smoking, high blood pressure, diabetes or high cholesterol.
      6. Physician has considered alternative treatment options (i.e. GI protective agent and non-selective NSAID such as acetaminophen, tramadol or a topical agent).
      7. Length of treatment has not exceeded 6 months.

2. PA Guidelines:
The PA must be initiated by the prescriber, except in long-term care facilities where the PA may be initiated and certified by the attending nurse after a review of the recipient's chart has been completed.

PA Form: Nevada Medicaid Prior Authorization Request for Cox II's form.

APPENDIX A – Coverage and Limitations

Nevada Medicaid

Prior Authorization Request for **COX-II**

TO BE COMPLETED BY PRESCRIBER

Prescriber Medicaid Provider Number ____-_____ Prescriber's Name:_____ First Last Phone ( ) FAX ( ) ***Phone & Fax must be completed***	Recipient Medicaid ID Number _____ Recipient's Name: First Last Date of Birth Sex: ☐ Female ☐ Male Request Date: / /

Drug/Clinical Information

Drug Requested:_____ Strength:_____ Dosage:_____ Length of Therapy:_____

Diagnosis & ICD9:_____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Nevada Medicaid Agency.

*Prescriber's Signature*_____ *Date*_____

Coverage Criteria

At least one of the FDA-approved indications below must be the treating diagnosis as a condition for payment for this drug by Nevada Medicaid. Please limit the request to one drug per request form. Supporting documentation does not need to be attached to this form, but must be available in the recipient's medical record.

Diagnosis of:

- ☐ Osteoarthritis
- ☐ Degenerative Joint Disease
- ☐ Rheumatoid Arthritis
- ☐ Dysmenorrhea
- ☐ Familial adenomatous polyposis (FAP)
- ☐ Acute Pain

Upon diagnosis of an FDA-approved indication, authorization will be given if the **patient meets ALL** of the following criteria:

1. Patient has no history of allergies to sulfonamides, aspirin or other NSAID's (non-steroidal anti-inflammatory drugs).
2. Patient has documented history of gastro-intestinal bleeding, ulceration or perforation of the stomach, small intestine OR is being treated with oral corticosteroids or anticoagulants.
3. Patient has a documented treatment history and/or failure of at least two non-selective (traditional) NSAIDs.
4. Patient is currently NOT being treated daily with aspirin for cardio-prophylaxis.
5. Patient does NOT have a documented treatment history of cardiac events (i.e. stroke, myocardial infarction, or has NOT undergone a coronary artery bypass graft procedure in the past 6 months) or major cardiac risk factors such as smoking, high blood pressure, diabetes or high cholesterol.
6. Physician has considered alternative treatment options (i.e. GI protective agent and non-selective NSAID such as acetaminophen, tramadol or a topical agent).
7. Length of treatment has not exceeded 6 months.

FIRST HEALTH SERVICES USE ONLY:

Comments:_____

Date: / / ☐Approved ☐Changed ☐Denied ☐Pending Add'l Info

MAP RPh/Tech:

Submit Requests to: First Health Services, MAP Department, 4300 Cox Road, Glenn Allan, VA 23060 — Fax: 1-800-229-3926, Tel: 1-800-505-9185

NMO/FH 3703 (01/03)

C. Agents used for the treatment of Attention Deficit Hyperactivity Disorder (ADHD)

Agents, both stimulants and non-stimulants used for the treatment of ADHD are a covered Nevada Medicaid benefit for the treatment of pediatric, adolescent, and adult clients that meet the criteria for coverage.

1. Coverage and Limitations:

Approval for medications will be given at the therapeutics class level if the following are met and documented:

a. General Criteria (Children and Adults)

1. Only one agent at a time may be used for the treatment of ADHD (applies to the entire ADHD/Stimulant Class); a 30-day transitional overlap in therapy will allowed.
2. The following two criteria must be met and documented in the recipient's medical record for adult and pediatric recipients in order for Prior Approval of CNS Stimulants:
   a. In the pediatric and adult population, the decision to medicate for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) and any comorbidty based on problems that are persistent and sufficiently severe to cause functional impairment in one or more of the following social environments: at school, home, work or with peers, and
   b. Before treatment with pharmacological methods is instituted, other treatable causes have been ruled out.

b. Children (up to age 18 years)

In addition to the general criteria above, the following must be present and documented in the recipient's medical record for Prior Approval of CNS Stimulants:

1. An initial evaluation has been done by the treating physician, pediatrician, psychiatrist or neurologist documenting the developmental history, physical evaluation, medical history or neurological primary diagnosis (e.g. fetal alcohol syndrome, thyroid disease) and examination within the past twelve months, or more recently, if the clinical condition has changed, and
2. One of the following:
   a. School information, Standardized Teachers Rating Scales testing reports such as TOVA (Test of Variables of Attention), achievement test, neuropsychological testing if indicated, Conner's scale, speech and language evaluation, or
   b. DMS-IV (Diagnostic and Statistical Manual of Mental Disorders) symptoms of ADD or ADHD, presence or absence-child behavior checklist, development and context of symptoms and resulting impairment, including school, family and peers, DSM-IV symptoms of possible alternate or comorbid psychiatric diagnosis, history of psychiatric, psychological pediatric or neurological treatment for ADD or ADHD, or
   c. Family history including diagnosis of ADD and ADHD, tic disorder, substance abuse disorder, conduct disorder, personality

disorder and other anxiety disorder, past or present family stressors, crises, any abuse or neglect, interview with parents.

3. The following two criteria must be met and documented in the recipient's medical record for adult and pediatric recipients in order for Prior Approval of CNS Stimulants:
   a. In the pediatric and adult population, the decision to medicate for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) and any comorbidity is based on problems that are persistent and sufficiently severe to cause functional impairment in one or more of the following social environments: at school, home, work or with peers, and
   b. Before treatment with pharmacological methods is instituted, other treatable causes have been ruled out.

c. Adults (18 years and above)

In addition to the general criteria above, the following must be present and documented in the recipient's medical record for Prior Approval for CNS Stimulants:

1. An initial evaluation-complete psychiatric assessment, present and past DSM-IV, symptoms of ADD or ADHD, history of development and context of symptoms and resulting past and present impairment, including academic achievement, IQ test and learning disorder evaluation, and
2. One of the following:
   a. Medical history, medical or neurological primary diagnosis (e.g. thyroid disease, head trauma), medication that could be causing symptoms (e.g. Phenobarbital, steroids), or
   b. History of other psychiatric disorder and treatment, or
   c. DSM-IV symptoms of ADD and ADHD presence or absence, possible alternate comorbid psychiatric diagnosis (especially: personality disorder, mood disorder, depression or mania, anxiety disorder, dissociative disorder, tic disorder including Tourette's disorder and substance abuse disorder), or
   d. Family history including diagnosis of ADD or ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder, mood disorder and anxiety disorder, possible family stressors, any history of abuse or neglect.

Prior Authorization will be given for a 1 year time period.

PA Form: Nevada Medicaid Prior Authorization Request for CNS Stimulants Adult and Pediatric forms.

APPENDIX A – Coverage and Limitations

Nevada Medicaid
Prior Authorization Request for
CNS Stimulants (for treatment of ADHD/ADD)
Pediatric Criteria (up to age 18 years)

To Be Completed By Prescriber

Prescriber Medicaid Provider Number	Recipient Medicaid ID Number
Prescriber's Name: First Last	Recipient's Name: First Last
Phone: ( )	Date of Birth: Sex: ☐ Female ☐ Male
Fax: ( )	Request Date
Phone and Fax must be completed	

Drug/Clinical Information

Drug Requested: Strength: Dosage: Length of Therapy:
Diagnosis & ICD.9:

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Nevada Medicaid Agency.
Prescriber's Signature: Date

Coverage Criteria

CHECK ALL APPLICABLE BOXES TO INDICATE THIS ITEM IS TRUE FOR RECIPIENT:
The following two criteria must be met and documented in the recipient's medical record for adult and pediatric recipients:

- ☐ The decision to medicate for ADD or ADHD and any comorbidity is based on problems that are persistent and sufficiently severe to cause functional impairment at school, home, work and/or with peers, and
- ☐ Other treatable causes have been ruled out.

Additional Criteria for Pediatric Recipients (up to age 18 yrs)
In addition to the above two criteria, the following must be met and documented in the recipient's medical record:

- ☐ Initial evaluation has been done by the treating physician documenting the developmental history, physical exam, medical history or neurological primary diagnosis and exam within the past twelve months, or more recently, if the clinical condition has changed, and
- ☐ **One of the following:**

A) School information, Standardized Teachers Rating Scales testing reports such as TOVA, achievement test, neurophsychological testing if indicated, speech and language evaluation, OR
B) DSM-IV symptoms of ADD or ADHD, presence or absence-child behavior checklist, development and context of symptoms and resulting impairment, including school, family and peers, DSM-IV symptoms of possible alternate or comorbid psychiatric diagnosis, history of psychiatric, psychological pediatric or neurological treatment for ADD or ADHD, OR
C) Family history including diagnosis of ADD and ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder and other anxiety disorder, past or present family stressors, crises, any abuse or neglect, interview with parents.

FIRST HEALTH SERVICES USE ONLY:

Comments:

Date: ☐Approved ☐Changed ☐Denied ☐Pending Add'l Info
MAP RPh/Tech:

Submit Requests to: **First Health Services**
MAP Department
4300 Cox Road
Glenn Allen, VA 23060

Fax: 1-800-228-3928
Tel: 1-800-505-9105

NMC/FH 1703 (01/03)

APPENDIX A – Coverage and Limitations

Nevada Medicaid
Prior Authorization Request for
CNS Stimulants (for treatment of ADHD/ADD)
Adult Criteria (age 18 years and above)

To Be Completed By Prescriber

Prescriber Medicaid Provider Number	Recipient Medicaid ID Number
Prescriber's Name: First Last	Recipient's Name: First Last
Phone: ( )	Date of Birth Sex: ☐ Female ☐ Male
Fax: ( )	Request Date:
Phone and Fax must be completed	

Drug/Clinical Information

Drug Requested: Strength Dosage: Length of Therapy:

Diagnosis & ICD9:

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Nevada Medicaid Agency.

Prescriber's Signature *Date*

Coverage Criteria

CHECK ALL APPLICABLE BOXES TO INDICATE THIS ITEM IS TRUE FOR RECIPIENT:

The following two criteria must be met and documented in the recipient's medical record for adult and pediatric recipients:

- ☐ The decision to medicate for ADD or ADHD and any comorbidity is based on problems that are persistent and sufficiently severe to cause functional impairment at school, home, work and/or with peers, and
- ☐ Other treatable causes have been ruled out.

Additional Criteria for Adult Recipients (age 18 yrs and above)

In addition to the above two criteria, the following must be met and documented in the recipient's medical record:

- ☐ Initial evaluation has been done including the complete psychiatric assessment, present and past DSM-IV, symptoms of ADD or ADHD, history of development and context of symptoms and resulting past and present impairment, including academic achievement, IQ test and learning disorder evaluation, and
- ☐ One of the following:

A) Medical history, medical or neurological primary diagnosis, medication that could be causing symptoms, or

B) History of other psychiatric disorder and treatment, or

C) DSM-IV symptoms of ADD and ADHD presence or absence, possible alternate comorbidity psychiatric diagnosis, or

D) Family history including diagnosis of ADD or ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder, mood disorder and anxiety disorder, possible family stressors, any history of abuse or neglect.

FIRST HEALTH SERVICES USE ONLY:

Comments:

Date: ☐Approved ☐Changed ☐Denied ☐Pending Add'l Info

MAP RPh/Tech:

Submit Requests to: First Health Services
MAP Department
4300 Cox Road
Glenn Allen, VA 23060

Fax: 1-800-229-3928
Tel: 1-800-505-9165

NMD/FH 3704 (01/03)

APPENDIX A – Coverage and Limitations

D. Growth Hormone

Growth Hormone therapy is a covered Nevada Medicaid benefit subject to Prior Authorization. All criteria must be met for children under 21 years of age. Adult cases will be reviewed on an individual basis.

1. Coverage and Limitations:

a. Children (up to age 21)

The following criteria must be met for children under 21 years of age:

Indications for growth hormone therapy in children are growth hormone deficiency, growth retardation secondary to chronic renal insufficiency up until renal transplantation and short stature of Turner's syndrome.

1. All other causes for short stature are ruled out.
2. Bone Age Study results show less than sixteen years for boys, less than 14 years for girls; epiphysis open. Bone age is at least two years less than chronological age.
3. Growth chart and declining growth velocity show growth less than fifth percentile. At least three documented measurements over the last six-month period.
4. Evaluation by a Pediatric Endocrinologist or Pediatric Nephrologist with a recommendation for therapy.
5. At least two provocative stimuli tests to show failure to raise growth hormone level above 10ng(nanograms)/ml. Exception: Patients with chronic renal insufficiency (CRI).
6. Baseline blood tests. Abnormalities to be corrected.
7. Turner's syndrome documented by karotyping.
8. Patient has not undergone renal transplant.
9. No expanding intracranial lesion or tumor diagnosis.
10. MRI or CT scan of head done on patients with multiple pituitary hormone deficiencies or history of intracranial lesions.

b. Criteria for continuation of growth hormone therapy includes the following:

1. Bone Age study shows less than sixteen years for boys, less than fourteen years for girls. Epiphysis open.
2. Growth rate with treatment is at least two cm. greater than untreated rate. Copy of the growth chart must accompany forms.
3. Child has not reached the 25th percentile of normal adult height for gender.
4. No diagnosis of an expanding lesion or tumor formation.
5. Patient has not undergone renal transplant.

c. Covered ICD-9 Codes:

253.2 Panhypotituitarism
253.3 Pituitary Dwarfism
253.7 Latrogenic pituitary disorders
Other disorders of the pituitary and other syndromes of diencepalohypophyseal origin
194.3 Other disorders of the pituitary gland and craniophryngeal duct
585 Chronic renal failure
588.9 Unspecified disorder resulting from impaired renal function
758.6 Gonadal dysgenesis/Turner's syndrome

d. Reasons for non-coverage/denial include, but are not limited to, the following:

1. Indications other than those specified in this policy;
2. Any condition(s) which is contraindicated and/or considered to be experimental;
3. Patients with expanding lesions or tumor formation;
4. Patients who have received renal transplantation; or
5. Patients who do not meet criteria as set by this policy.
6. Also, growth rate that is less than 2.0 cm/yr of untreated rate; growth that has reached the 25% of normal adult height for gender; bone age that is over recommended age for gender; or if ephiphysis is closed.

An evaluation by a pediatric Endocrinologist or a pediatric Nephrologist is mandatory for initiation of Growth Hormone therapy and close monitoring either by a pediatric Endocrinologist, pediatric Nephrologist or the recipient's primary care physician is required throughout therapy.

Prior Authorization will be given for a 6 month time period for initiation of therapy, and 6-12 months for continuation of therapy, dependant upon the response of growth by the recipient.

c. Adults (age 21 and older)
Adult cases must be reviewed on an individual basis. Contact the Nevada Medicaid QIO-like vendor for further information.

2. PA Guidelines:
The appropriate form and PA are to be completed by the prescriber and submitted to the Nevada Medicaid QIO-like vendor.

Please Note: Service is to be done by an in-state provider. Service may be provided by an out-of-state provider only if service is unavailable in-state and/or recipient resides out-of-state.

PA Form: Nevada Medicaid Growth Hormone Therapy form.

Nevada Medicaid Request for Prior Authorization Of Growth Hormone

Fax to First Health Services at: 800-229-3928

Patient Name: _____

Medicaid ID #: _____ **Date of Birth** ____/____/____

Prescribing Physician Name: _____

Contact Person at Office: _____

Medicaid ID #: _____

Phone #: ( ) _____ **Fax #:** ( ) _____

Drug Name: _____ **Strength:** _____ **Duration:** _____

Diagnosis : _____ **ICD-9 CODE** _____

Initiation of Therapy _____**yes**_____**no** **Continuation of Therapy** _____ **yes**_____**no**

Bone age studies results _____

Epiphyses_____**open** _____**closed, Is Bone Age < 2yrs Chronological Age**_____**yes**_____**no**

Is growth < 5th Percentile_____**yes**_____**no, Growth Hormone level**_____**ng/ml,** _____**date**

Has Patient been evaluated by Endocrinologist_____**Nephrologist**_____

Does Patient have Chronic Renal Insufficiency (CRI) _____**yes** _____**no**

Has Patient received Renal Transplant_____**yes**_____**no**

Does Patient have expanding intracranial lesions or tumor diagnosis_____**yes**_____**no, If yes, Has CT of head or MRI been done**_____**yes** _____**no**

If patient has Multiple Pituitary Hormone Deficiencies has MRI or CT of head been done_____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Nevada Medicaid Agency.

Prescriber's Signature: _____ **Date:** _____

Mail requests to: First Health Services, MAP Department, 4300 Cox Road, Glen Allen, VA 23060
Call into: 800-505-9185

APPENDIX A – Coverage and Limitations

E. Over-the-Counter Medications

Over-the-Counter medications are a covered Nevada Medicaid benefit subject to Prior Authorization.

1. Coverage and Limitations:

Two prescriptions per month within the same Standard Therapeutic Class (please see Appendix B for a list of Standard Therapeutic Classes) will be allowed without PA. Any more than two prescription requests for medications within the same therapeutic class will require PA.

A PA form must be submitted to the Nevada QIO-like vendor. The QIO-like vendor will request further information needed on a case by case basis to determine the necessity of the medication for the recipient.

Note: Insulin will be exempt from any PA requirements.

Approval will be for a one month time limit.

PA Form: generic Nevada Medicaid Request for Prior Authorization form.

F. Duragesic ® (fentanyl transdermal) Patches

Transdermal fentanyl, a narcotic agonist analgesic, is indicated in the management of chronic pain in patients requiring continuous opioid analgesia for pain that cannot be managed by lesser means such as acetaminophen-opioid combinations, non-steroidal analgesics or PRN dosing with short-acting opioids. Transdermal fentanyl is a covered Nevada Medicaid benefit subject to Prior Authorization.

1. Coverage and Limitations:

Because serious or life-threatening hypoventilation could occur, fentanyl transdermal is contraindicated in management of acute or postoperative pain, mild or intermittent pain responsive to PRN or non-opioid therapy, or in doses exceeding 25 mcg/hr at the initiation of opioid therapy. Therefore, patients must meet the following two criteria in order to gain PA approval:

a. Patient cannot be managed by lesser means such as acetaminophen-opioid combinations, nonsteriodal analgesics, or PRN dosing with short-acting opioid.
b. Patient requires continuous opioid administration.

In addition the following guidelines apply:

a. Dosing interval 1 patch every 3 days; may be dosed every two days if failure to achieve pain relief is documented and clinical notes are provided to clinical call center
b. Do not authorize if on long-acting narcotics. If recipient is switching to fentanyl and has a prior authorization for a long-acting narcotic, discontinue the prior authorization for the long-acting narcotic and inform the prescriber.

Prior approval will be given for a 6 month time period.

APPENDIX A – Coverage and Limitations

PA Form: generic Nevada Medicaid Request for Prior Authorization form.

G. Hematopoietic/Hematinic Agents

Hematopoietics and Hematinics are a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage.

1. Coverage and Limitations:

Approval will be given for the use of Red Blood Cell Building Hematopoietics and Hematinics if a diagnosis of anemia and the cause (e.g. chronic renal failure, myelosuppressive chemotherapy) is documented and confirmed by blood test.

Prior approval will be given for a one month period.

PA Form: generic Nevada Medicaid Request for Prior Authorization form.

H. Anti-Fungal Onycyhomycosis (Lamisil®, Sporanox®, Penlac®)

Anti-Fungal Onchomycosis are a covered benefit for recipients who meet the criteria for coverage.

1. Coverage and Limitations:

Authorization will be given if the following criteria are met and documented:

a. Do not authorize itraconazole if recipient has evidence of ventricular dysfunction.
b. Do not authorize terbinafine if recipient has pre-existing liver disease.
c. Positive KOH stain, positive PAS stain or positive fungal culture and any of the following:
   1. Recipient experiencing pain which limits normal activity
   2. Recipient has an iatrogenically-induced or disease associated immunosuppression
   3. Recipient has diabetes
   4. Recipient has significant peripheral vascular compromise
d. Length of Authorization:
   1. Lamisil® & Sporanox Fingernail: 6 weeks
      Toenail: 12 weeks
   2. Penlac® Initial: 3 months
      Follow-up: 3 months (Up to 12 months)

2. PA Guidelines:

PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

I. Altace ® (ramipril)

Altace is a covered benefit for recipients who meet the criteria for coverage.

1. Coverage and Limitations:

Do not authorize if recipient is pregnant.

Authorization will be given if one of the following criteria are met and documented:

1. History of stroke
2. Recipient has peripheral vascular disease
3. History of coronary artery disease
4. Diabetes with microalbuminuria

2. PA Guidelines:
PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

J. Neurontin ® (gabapentin)

Neurontin ® is a covered benefit for recipients who meet the criteria for coverage.

1. Coverage and Limitations:
Authorization will be given if the following criteria are met and documented.

All patients with a previous claim for Neurontin® on the prior authorization initiation date will be "grandfathered" for 90 days.

a. Diagnosis of epilepsy authorization given for life
b. Diagnosis of diabetic neuropathy, postherpetic neuralgia, documented neuropathies or neuralgia:
   1. Continuation of therapy authorize for 1 year
   2. Initiation of therapy authorize for 90 day trial
   2. Positive response during the 90 days authorize for 1 year
c. Diagnosis of migraine:
   1. Continuation of therapy authorize for 1 year
   2. Initiation of therapy authorize for 90 day trial
   3. Positive response during the 90 days authorize for 1 year
d. Diagnosis of bipolar affective disorder
   1. Continuation of therapy authorize fro 1 year
   2. If recipient has been tried and failed on lithium, carbamazepine, and valproic acid authorize for 90 day trail
   3. Contraindication for the above treatment, authorize for 90 day trial
   4. Positive response during the 90 days authorize for 1 year

2. PA Guidelines:

PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

K. Standard Preferred Drug List Exception Criteria

Drugs that have a "non-preferred" status are a covered benefit for recipients if they meet the coverage criteria.

1. Coverage and Limitations:
Authorization will be given to utilize a non-preferred drug if one of the following criteria is met:
   1. Allergy to all preferred medications within the same class.
   2. Contraindication to or drug-to-drug interaction with all preferred medications within the same class.

3. History of unacceptable/toxic side effects to all preferred medications within the same class.
4. Therapeutic failure of two preferred medications within the same class. If there are not two preferred medications within the same class therapeutic failure only needs to occur on the one preferred medication.
5. An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or a FDA-approved indication.
6. Antidepressant Medication – Continuity of Care. Recipients discharged from acute mental health facilities on a non-preferred antidepressant will be allowed to continue on that drug for up to 90 days following discharge. After 90 days, the recipient must meet one of the above five (5) PDL Exception Criteria.

2. PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

2. DRUGS WITH QUANTITY LIMITATIONS

A. Long-Acting Narcotics

Long Acting Narcotics are a covered benefit of Nevada Medicaid, for recipients who meet the coverage criteria.

1. Coverage and Limitations:
Indications:
Management of moderate-to-severe pain when continuous around-the-clock analgesic is needed for an extended period of time.
Medications:

Brand Names	Generic Names	Dosage Strength	Dosage Form
Avinza®	Morphine Extended Release	30, 60, 90, 120mg	Capsules
Kadian®	Morphine Sustained Release	20, 30, 50, 80, 100mg	Capsules, sustained-Release pellets
MS Contin®	Morphine Controlled Release	15, 30, 60, 100, 200mg	Tablets
	Morphine Sulfate Extended Release	15, 30, 60, 100mg	Tablets
Oramorph®	Morphine Sulfated Controlled Release	15, 30, 60, 100mg	Tablets
Oxycontin®	Oxycodone Extended Release	10, 20, 40, 80mg	Extended Release Tablets

a. Oxycontin (including generic)
   1. Any dosing greater than three (3) tablets per day of any one strength will require a prior authorization.
   2. No prior authorization is required for diagnosis of terminal cancer
b. MS Contin (including generic)
   1. Any dosing greater than three (3) tablets per day of any one strength will require a prior authorization.
   2. No prior authorization is required for a diagnosis of terminal cancer.

c. Avinza

1. Any dosing greater than one (1) capsule per day of any one strength will require a prior authorization.
2. No prior authorization is required for a diagnosis of terminal cancer.

d. Kadian
1. Any dosing greater than two (2) capsules per day of any one strength will require a prior authorization.
2. No prior authorization is required for a diagnosis of terminal cancer

e. Please Note: The use of Long Acting Narcotics for acute/short term treatment of pain not within the quantity limits will not be approved.

Approval will be for a three (3) month time limit.

b. PA Guidelines:

The PA must be initiated by the prescriber. The approved PAR must be available if requested.

PA Form: generic Nevada Medicaid Request for Prior Authorized form.

B. Toradol® (ketorolac tromethamine) tablets

The pharmaceutical Toradal® is a covered benefit for recipients who meet the criteria for coverage.

1. Coverage and Limitations:
Ketorolac is indicated for the short-term (up to 5 days) management of moderately severe acute pain that requires analgesia at the opioid level. It is not indicated for minor or chronic painful conditions. The following criteria must be met:
a. Oral treatment is indicated only as continuation therapy to IV/IM therapy.
b. Oral treatment is not to exceed 5 days.
A prescription for 20 or less tablets per month may be obtained without PA. If the prescription is for a quantity of more than 20 tablets in the past 6 months, a PA must be obtained through the Nevada Medicaid QIO-like vendor.
2. PA GUIDELINES
The PA must be initiated by the prescriber. The approved PA must be available if requested.

PA Form: generic Nevada Medicaid Request for Prior Authorization form.

C. Anti-migraine medications (triptans)

Serotonin 5-HT1 receptor agonists commonly referred to as "triptans" or anti-migraine medications are a covered benefit of Nevada Medicaid subject to quantity limitations.

1. Coverage and Limitations:
Nevada's Preferred Drug List now includes all dosage forms of zolmitriptan (Zomig®), which includes a nasal spray, all dosage forms of rizatriptan (Maxalt®), which includes a rapidly dissolving oral tablet and sumatriptan (Imitrex®) injectable*. The number of

tablets/doses allowed per month is restricted on triptans. Only one prescription of triptans per month is allowable without PA. Nevada Medicaid restricts the allowable number of tablets/doses per month per the following table:

Brand Name	Generic Name	Strength	Dosage Form	How Supplied	Limit Per Month
Amerge	Naratriptan	1mg	Tablet	9 tablets/package	9 tablets
		2.5mg	Tablet	9 tablets/package	9 tablets
Axert	Almotriptan	6.25mg	Tablet	6 tablets/package	6 tablets
		12.5mg	Tablet	6 tablets/package	6 tablets
Frova	Frovatriptan	2.5mg	Tablet	9 tablets/package	9 tablets
Imitrex	Sumatriptan	25mg	Tablet	9 tablets/package	18 tablets
		50mg	Tablet	9 tablets/package	9 tablets
		100mg	Tablet	9 tablets/package	9 tablets
		6mg	Injection	2 injections/package	4 injections*
		5mg	Nasal Spray	6 units/package	12 units
		20mg	Nasal Spray	6 units/package	6 units
Maxalt	Rizatriptan	5mg	Tablet	6 tablets/package	12 tablets*
		10mg	Tablet	6 tablets/package	12 tablets*
Maxalt-MLT		5mg	Orally Disintegrating tablet	2 units of 3 tab/pack	12 tablets*
		10mg	Orally Disintegrating tablet	2 units of 3 tab/pack	12 tablets*
Zomig	Zolmitriptan	2.5mg	Tablet	6 tablets/package	12 tablets
		5mg	Tablet	3 tablets/package	6 tablets
Zomig ZMT		2.5mg	Orally Disintegrating tablet	6 tablets/package	12 tablets
		5 mg	Nasal Spray	6 units/package	12 tablets*

An approved PA is required for any prescription exceeding the above outlined quantity limits.

* Now on Nevada's PDL.

Approval for additional medication beyond these limits will be considered only under the following circumstances:

a. The recipient's current medication history documents the use of prophylactic medications for migraine headache or the medical provider agrees to initiate such therapy with includes beta-blockers, tricyclic antidepressants, anticonvulsants, selective serotonin reuptake inhibitors (SSRIs) and/or calcium channel blockers, OR

b. The medical provider is aware of and understands the implications of daily use and/or overuse of triptans and agrees to counsel the patient on this issue in an effort to taper the quantity of triptan medication required monthly.

- Recipient's current medication history must NOT have MAO (Monoamine Oxidose) Inhibitors present for approval of Imitrex® (sumitriptan), Maxalt® (rizatriptan) or Zomig® (zolmitriptan).
- Recipients whose current medication history indicates the use of propranolol will NOT be granted prior authorization of Maxalt® (rizatriptan) 10mg tablet or 10mg orally disintegrating tablet.

- Prior authorization will NOT be given to patients with ischemic heart disease.

Approval for exceeding the quantity limits on triptans will be given for a two month time period.

2. PA Guidelines:
The PA must be initiated by the prescriber. The approved PA must be available if requested.

PA Form: generic Nevada Medicaid request for Prior Authorization form.

D. Smoking cessation products

Smoking cessation products, including patches, gums, lozenges and inhalers, are a covered Nevada Medicaid benefit subject to quantity limitations.

1. Coverage and Limitations:
Smoking cessation products are limited to two (2) 90 day therapy sessions, using the route of their choice, per year.

E. Actiq ® (fentanyl citrate)

Actiq ® is a covered benefit for recipients that meet the coverage criteria.

1. Coverage and Limitations:
   1. Diagnosis of pain unresponsive to other therapy, and
   2. Failure of two (2) short-acting narcotics.
   c. Limit: 4 units per day
2. PA Guidelines:

PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

F. Xopenex ® (levalbuterol)

Xopenex ® is a covered benefit for recipients that meet the coverage criteria.

1. Coverage and Limitations:
   a. Authorization only for recipients experiencing side effects on one other beta-adrenergic agent of any formulation
   b. Authorization for patients whose cardiovascular status is considered to be in severe deteriorating condition.
   c. Xopenex 0.31mg and 0.63mg cannot be dosed more than every 6 hours or as needed.
   d. Xopenex 1.25mg cannot be dosed more than every 8 hours or as needed.
   e. Maximum quantity per month = 4 boxes (288ml)

2. PA Guidelines:

PA Form: Generic Nevada Medicaid Request for Prior Authorization Form

G. Sedative Hypnotics

Sedatives Hypnotics are a covered Nevada Medicaid benefit subject to quantity limitations.

1. Coverage and Limitations:
   Quantity limit of 30 tablet per month of only one strength

H. Inhaled Anticholinergic Agents

Inhaled anticholinergic agents are a covered benefit of Nevada Medicaid

1. General Criteria
   a. Only one inhaled anticholinergic agent may be used in a 30 day period.

I. See table for Quantity Edits Approved at DUR Board 12-16-2004:

APPENDIX A – Coverage and Limitations
QUANTITY EDITS APPROVED AT DUR BOARD 12-16-2004

Quantity Edit					
December – 04					
Drug Name	HCL	GSN	NDC	Maximum Quantity Per RX	Reason
Anzemet 100mg		34750		2.0	Edit designed to ensure appropriate dose, duration of therapy and indication.
Anzemet 50mg		34749		4.0	Same
Emend 80mg		51911		1.0	Same
Emend 125mg		51912		2.0	Same
Kytril 1mg		21592		2.0	Same
Zofran ODT 4mg		41562		12.0	Same
Zofran ODT 8mg		41563		6.0	Same
Zofran 4mg		16392		12.0	Same
Zofran 8mg		16393		6.0	Same
Zofran 24mg		43230		1.0	Same
Zofran Solution		15869		1 bottle (50 ml)	Same
Copaxone 20mg Kit			00088115330	1.0	Provider should be billing eaches, not milligrams
Duoneb	009040			6 bottles per month	Maximum needed
Duragesic				15	Maximum allowed
Flovent Rotadisk 100mcg		19317		1 box per month	Maximum needed
Flovent Rotadisk 250mcg		19318		1 box per month	Same
Flovent Rotadisk 50mcg		19319		1 box per month	Same
Lovenox 30mg/0.3ml		19331		18.0	Maximum daily dose should be BID, therefore no more than 60 syringes should be dispensed per RX.
Lovenox 40mg/0.4ml		39482		24.0	Same
Lovenox 60mg/0.6ml		27993		36.0	Same
Lovenox 80mg/0.8ml		27994		48.0	Same
Lovenox 100mg/ml		27995		60.0	Same
Lovenox 120mg/0.8ml		44669		48.0	Same
Lovenox 150mg/ml		44668		60.0	Same
Neupogen	006070			15.0	Providers should be billing by eaches and not micrograms
Rebif	023353			6.0	To prevent overbilling for number of syringes dispensed instead of ml's
Serevent Diskus		31417		1 box (60 inhalations per month)	Maximum needed

Synagis 100mg Vial		40293		4.0	This was the largest correct quantity submined since 01/01/04
Xopenex (All Strengths)		49871, 41849, 41848		4 boxes (288ml) per month	Maximum needed

APPENDIX A – Coverage and Limitations

3. MEDICATIONS WITH GENDER/AGE EDITS

A. Prenatal vitamins

1. Payable only for female recipients.

B. Oral/Topical Contraceptives

1. Payable only for female recipients.

3. Hormones

1. Estrogen – payable only for female recipients.
2. Progestins – payable only for female recipients.
3. Estrogen and Androgen Combinations – payable only for female recipients.
4. Estrogen/Progestin Combinations – payable only for female recipients.
5. Contraceptive Hormones – payable only for female recipients.
6. Transdermal Testosterone – payable only for male recipients.
7. Androgen Hormone Inhibitor – payable only for male recipients.

4. Vitamins with Flouride

1. Payable only for recipients up to age 21 years.

5. Tretinoic Acid Cream/Ointment/Gel

1. Payable only for recipients up to age 21 years.

6. Synagis ® Palivizumaub

Synagis® (palivizumab) injection is a covered benefit of Nevada Medicaid for recipients under the age of 2 years who meet the criteria. A Prior Authorization is not required for recipients within the indications and limitations of coverage. For consideration outside these guidelines, a PA may be submitted with supporting medical justification documentation.

1. Coverage and Limitations:
Recipients must meet one of the following criteria:
   a. Less than 2 years old at start of Respiratory Syncytial Virus (RSV) season, with Chronic Lung Disease (CLD) and have required medical therapy for their CLD within 6 months before the anticipated RSV season, OR
   b. Premature infant with a gestational age of 28 weeks or less and is twelve (12) months of age or less at the start of RSV season , OR
   c. Premature infant with a gestational age or 29-32 weeks and is six (6) months of age or less at the start of RSV season, OR
   d. Premature infant with gestational age 32-35 weeks and is six (6) months of age or less at the start of RSV season with one or more of the following risk factors:
      - passive smoke exposure

- day care attendance
- school age siblings
- multiple birth
- two or more individuals sharing a bedroom
- birth within six (6) months before onset of RSV season, OR

e. Less than 2 years of age with severe immunodeficiency disease.
f. Infants meeting criteria in the above 1, 2 or 3 and who also have asymptomatic acyanotic congenital heart disease.

The product must be administered between October 1st and April 30th. Only one dose (based on recipient weight) may be given in a 30 day period.

If Synagis is administered outside these guidelines without PA, the cost of the medication will be recouped from the pharmacy.

Approval will be given on a per RSV season basis.

2. PA Guidelines:

Provider Type 20: Submit a HCFA 1500 form with CPT code 90378 (enter one (1) unit of this code for every 50mg, or portion thereof, of the drug administered-for example if 120mg was given, this code will have 3 units) and attach invoice. Enter CPT 90782 for administration code. Enter the appropriate diagnosis code.

Provider Type 28: Submit an online or UCF (Universal Claim Form) claim using the appropriate NDC. The quantity entered will be the number of vials administered per single dose. For example, if a recipient receives 120mg, bill for one (1) 100mg vial and one (1) 50mg vial.

Note: Providers may bill for one vial even if only part of the single-use vial was given to the recipient and the remainder of the drug was discarded. Safe handling guidelines per manufacturer must be observed (e.g. shelf life, cold chain requirements). The smallest size vial to cover the dose must be used. For example, if the appropriate dose is 120mg, one (1) 100mg vial and one (1) 50mg vial should be used, the provider may not bill for two (2) 100mg vials in this case.

7. Zelnorm ®

Zelnorm ® is a covered benefit subject to quantity and gender edits.

1. COVERAGE AND LIMITATIONS
   a. Gender: Female
2. Maximum treatment 12 weeks. A new prior authorization is required to continue therapy beyond 12 weeks.

4. ANTIRETROVIRALS

Antiretrovirals for the treatment of HIV (Human Immune deficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) are a covered benefit for Nevada Medicaid recipients. FDA approved

Antiretrovirals whose manufacturers participate in the federal Drug Rebate Program and are not DESI drugs, are covered.

Please Note: Until 07/01/03 Anitretrovirals are excluded from the Medicaid HMO benefit package and will be provided to Medicaid HMO recipients under Medicaid Fee-for-Service. They are to be billed directly to Nevada Medicaid's Fiscal Agent.

Beginning 07/01/03, antiretrovirals will be part of coverage under Medicaid HMO benefit packages.

5. BLOOD GLUCOSE TESTING

Blood glucose monitors and testing supplies for home use are a covered Medicaid benefit. A written prescription with a diagnosis is required and must be kept on the premise of the provider for 37 months. A recipient or their caregiver must specifically request refills of glucose supplies before they are dispensed. The provider must not automatically dispense a quantity of supplies on a predetermined regular basis, even if a recipient has "authorized" in advance.

No Prior Authorization is required for the items in the outlined quantities below:

Lancets	200/month
Alcohol Swabs	200/month
Battery for Monitor	1/year
Blood Glucose Monitor	1 every 2 years (not to exceed $55/monitor)
Blood Glucose Strips	200/month
Insulin Syringes	100/month
Keto-Stix	100/month
Control Solution	1/month

For all other items/quantities in excess of those outlined above, a Prior Authorization must be obtained from the Nevada Medicaid QIO-like vendor.

Blood Glucose monitors with special features (e.g. voice synthesizers) require a Prior Authorization. For special blood glucose monitors, the recipient must be legally blind. A diagnosis, a statement from the physician of visual impairment, and manufacturers' invoice in required with the PA.

ICD-9 codes 250.00 through 250.93 (Diabetes Mellitus) or 648.0 (Diabetes Mellitus complicating pregnancy) will be covered. No coverage will be provided for any other ICD-9 code.

Blood glucose monitors and related supplies are billed on the NCPDP Universal Claim Form (UCF) or on-line through the POS (Point of Sale) system with the correct NDC number, complete description, including brand name and package size. Reimbursement is 90% of average wholesale price plus and handling and dispensing fee of $1.58 per prescription.

APPENDIX B
Standard Therapeutic Drug Classes

FIRST HEALTH AD HOC REPORTING SYSTEM
STANDARD THERAPEUTIC CLASSES

Standard Therapeutic Class	Description
00	MEDICAL SUPPLIES
01	ANTI-ULCER PREPS/GASTROINTESTI
02	EMETICS
03	ANTIDIARRHEALS
04	ANTISPASMODIC-ANTICHOLINERGICS
05	BILE THERAPY
06	LAXATIVES
07	ATARACTICS-TRANQUILIZERS
08	MUSCLE RELAXANTS
09	ANTIPARKINSON
10	CNS STIMULANTS
11	PSYCHOSTIMULANTS-ANTIDEPRESSAN
12	AMPHETAMINE PREPARATIONS
13	ALL OTHER ANTIOBESITY PREPS
14	ANTIHISTAMINES
15	BRONCHIAL DILATORS
16	COUGH PREPARATIONS/EXPECTORANT
17	COLD AND COUGH PREPARATIONS
18	ADRENERGICS
19	TOPICAL NASAL AND OTIC PREPARA
20	OPHTHALMIC PREPARATIONS
21	TETRACYCLINES
22	PENICILLINS
23	STREPTOMYCINS
24	SULFONAMIDES
25	ERYTHROMYCINS
26	CEPHALOSPORINS
27	OTHER ANTIBIOTICS
28	URINARY ANTIBACTERIALS
29	CHLORAMPHENICOL
30	ANTINEOPLASTICS
31	ANTIPARASITICS
32	ANTIMALARIALS
33	ANTIVIRALS
34	TB PREPARATIONS
35	TRIMETHOPRIM
36	CONTRACEPTIVES, NON-SYSTEMIC
37	VAGINAL CLEANSERS
38	GENERAL ANTIBACTERIALS AND ANT
39	DIAGNOSTICS
40	NARCOTIC ANALGESICS
41	NON-NARCOTIC ANALGESICS
42	ANTIARTHRITICS
43	ANESTHETICS GEN INHALANT

APPENDIX B
Standard Therapeutic Drug Classes

44	ANESTHETICS GEN INJECT
45	ANESTHETIC LOCAL TOPICAL
46	SEDATIVE BARBITURATE
47	SEDATIVE NON-BARBITURATE
48	ANTICONVULSANTS
49	ANTINAUSEANTS
50	CORTICOTROPINS
51	GLUCOCORTICOIDS
52	MINERALOCORTICOIDS
53	ALDOSTERONE ANTAGONISTS
54	ANTIDOTES
55	THYROID PREPS
56	ANTITHYROID PREPS
57	IODINE THERAPY
58	DIABETIC THERAPY
59	ANABOLICS
60	ANDROGENS
61	ESTROGENS
62	PROGESTERONE
63	SYSTEMIC CONTRACEPTIVES
64	OTHER HORMONES
65	LIPOTROPICS
66	CHOLESTEROL REDUCERS
67	DIGESTANTS
68	PROTEIN LYSATES
69	ENZYMES
70	RAUWOLFIAS
71	OTHER HYPOTENSIVES
72	VASODILATORS CORONARY
73	VASODILATORS PERIPHERAL
74	DIGITALIS PREPARATIONS
75	XANTHINE DERIVATIVES
76	OTHER CARDIOVASCULAR PREPS
77	ANTICOAGULANTS
78	HEMOSTATICS
79	DIURETICS
80	FAT SOLUBLE VITAMINS
81	WATER SOLUBLE VITAMINS
82	MULTIVITAMINS
83	FOLIC ACID PREPARATIONS
84	B COMPLEX WITH VITAMIN C
85	VITAMIN K
86	INFANT FORMULAS
87	ELECTROLYTES & MISCELLANEOUS N
88	HEMATINICS & BLOOD CELL STIMUL
89	ALLERGENS
90	BIOLOGICALS
91	ANTIPRURITICS
92	COAL TAR
93	EMOLLIENTS PROTECTIVES

APPENDIX B
Standard Therapeutic Drug Classes

94	FUNGICIDES
95	ALL OTHER DERMATOLOGICALS
96	HEMORRHOIDAL PREPARATIONS
97	OXYTOCICS
98	PARASYMPATHETIC AGENTS
99	MISCELLANEOUS